



## Application to the Practical Nursing Program

Thank you for your interest in the LPN program at Monroe Community College! The LPN program is a 13-month program with 1200 hours of clinical, lab, and classroom hours. Students must maintain attendance in classroom/lab/clinical, prove competency in LPN skills, and maintain a minimum of 80% grade in each course to continue to the next quarter. Each applicant should consider many factors, to include:

1. As a clock hour program, attendance is mandatory.
2. Each student should figure 2 hours of outside study, homework, or other to every one classroom and lab hour.
3. Flexibility is required to accommodate the completion of required hours. Please take a moment to look at your schedule to assure that this works for you and your family.

## Admissions Requirements

To apply for the Practical Nursing Program applicants must:

- Have proof of a United States high school diploma or GED diploma
- Proof of US Citizenship or legal status allowing enrollment in program
- Be at least 18 years old to obtain a New York State Practical Nursing license.
- Successfully pass Test of Essential Academic Skills (TEAS) test (minimum score of 41 in reading, language, math, and science)
- Submit a professional application packet to the program
- Professional Interview

## Application Process and Packet

1. **Schedule Professional Interview at least two weeks prior to application deadline**
  - [Email Kelsey Klopfer \(kklopfer@monroecc.edu\)](mailto:kklopfer@monroecc.edu)
    - Select an interview time (if available)
    - Provide your name, phone number, and email
    - Watch for an email providing you with an interview time
2. **Letter of interest, professional resume, and application. Must be typed, nothing handwritten will be accepted**
  - Simple Microsoft Resume Template can be used
  - Letter of interest merely needs to state date, name, address, statement such as “Please accept my application for the LPN program. I have attached the following documents for your review: ...”
3. **Copy of high school diploma/GED**
4. **3 Letters of reference:** 2 Professional (1 from a current Supervisor, both must be on company letterhead) and 1 from an outside resource/support person who is in a position to help and assist the candidate throughout the 13-month program. Must contain signature.

**A suggested request letter is provided in the packet. Must be sent directly to the program manager.**

(Note: If a candidate has attended training programs at MCC, performance in that program will be considered when selecting candidates to the LPN program.)

5. **TEAS test scores with minimal score of 41 on all four sections**
  - a. All candidates who attain a Proficient score on all four sections are invited to continue to apply directly to the LPN program.
  - b. Candidates that do not attain Proficient on all four sections but attain a Basic in at any one of the four exams will be invited to attend a Clinical Bridge class to strengthen their academic

foundation prior to applying to the program.

**All candidates must pass each of the four TEAS exams with a Basic score or higher.**

6. **Professional Essay:** In this essay include why you should be selected for this program, why you would make a great LPN, and any other factors that you think should impact the team's selection decision. Remember that this will be evaluated as an academic and professional writing sample.
  - Rubric attached
7. **Complete an Academic and Financial Plan**
  - An academic plan is a student's intended schedule with all responsibilities indicated to include study time, class time, homework time, work schedule, etc. This is your time management plan. Any calendar template will do – please provide one month as a sample. In the notes section of the page, please indicate any significant life events that may impact one's ability to attend class, study, or complete homework.
  - Fall schedule: Two nights per week, Friday, Saturday (8-4) and Sundays (630-330) for clinical.
  - A financial plan details a person's current financial circumstances throughout the year-long program. The recurring financial responsibilities, income, outside obligations (birthdays, etc). This is to provide assurances to both the student and the program that each candidate has a viable plan to sustain themselves and their family throughout the year long program. Microsoft has a spreadsheet or google monthly budget (docs.google.com).
8. **Complete and submit the provided Health Release form (attached to the packet)**

## Acceptance

Selections are based on the following criteria and subject to available seats:

- A. TEAS test scores:
  - a. Individuals who achieve proficient in all four sections will be reviewed first.
  - b. Individuals who receive proficient overall and 45 or higher on all four sections will be reviewed second.
  - c. Individuals who receive Basic and Basic overall and have attended the Bridge program will be reviewed last.
- B. Review of submitted material
- C. Performance in Bridge program or other training programs at MCC

The admissions team of instructors, coaches and administrator will consider the applicant's TEAS test scores and the required documents in order to make the best selections. Candidates will be notified within 2 weeks of submission date.

## Preparing to Apply

Upon indicated interest, future applicants will be e-mailed information about the content of the entrance exam (TEAS 7) as well as resources to help prepare.

Resources, such as a study guide and outline practice test (TEAS 7), can be purchased directly through [Assessment Technologies Institute \(ATI\) \(https://www.atitesting.com/teas/study-manual\)](https://www.atitesting.com/teas/study-manual).

In addition, a TEAS test preparation course is also offered at MCC. This is an optional course designed to improve reading comprehension, review scientific knowledge, and enhance math skill. Instruction in test taking strategies and effective study skills is included. Taking this course does not guarantee placement in the PN program. Please call at phone number to obtain course schedule offerings.

## *Clinical Bridge Program*

To better prepare students for the content and rigor of an LPN program, MCC offers a Clinical Bridge program for individuals who have successfully passed the TEAS test with a minimum score of 41 on all four test sections (Math, Science, Reading, and English Language). Throughout the four weeks (20 hours per week) prior to the start of the LPN program, students will gain a greater foundation in the content areas of Math, Science, and English, as well as study and test taking strategies. Students will get a feel for the structure and rigor of an LPN

program to better inform their choice to enroll and their plan for success. This is offered as a P/F. Students must pass to be considered for enrollment in the LPN program.

### ***Medical Clearance (Health Release Form)***

Medical clearance must be obtained in order to participate in this training program. This immunizations/ blood work verification requirement is indicated on the authored physical examination form and **MUST** be completed by a physician.

### **Tuition Payments/Costs**

Currently, MCC has obtained grant funding for the TEAS test prep, the Clinical Bridge program, and most of the LPN program. Applicants will also be required to apply for funding through RochesterWorks or other outside funding entities.

- To be eligible, applicants will need to complete paperwork and follow up with Success Coaches.

### **Important**

Please submit all material together in one folder in the following order:

- Letter of Intent
- Resume
- Application
- copy of HS Diploma/GED
- 3 letters of reference
- TEAS test report
- Professional Essay
- Academic Plan
- Financial Plan
- Health Release



**Monroe Community College**

STATE UNIVERSITY OF NEW YORK

## LPN Program Application

Name: \_\_\_\_\_ Cell: \_\_\_\_\_

E-mail: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Education: HSD \_\_\_\_\_ GED \_\_\_\_\_ High School Name: \_\_\_\_\_

Current Employer: \_\_\_\_\_ Title: \_\_\_\_\_

Is your employer supportive of your interest in enrolling in an LPN program? \_\_\_\_\_

### Attached Documents

HS Diploma/GED

Essay

Reference 1 (Current Supervisor)

Academic Plan

Financial Plan

Reference 2 (Current support)

Health Release form

TEAS test results

Reference 3 (Other)

Resume

Interest letter

Please **initial** in the space provided:

I understand that this is a 13-month program that may require flexibility to schedule clinical, lab, and classroom experiences.

I understand that I am only able to miss a maximum of 30 hours of classroom/lab/or clinical throughout this 13-month program and that all time is to be made up in order to complete the program.

If I am selected, I will commit to completing all work assigned and required and that I agree to take the NCLEX within 90 days of completing the program.

I have divulged any criminal background that may be on my record.

I attest that all of the information provided is accurate to the best of my knowledge:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

### Application Questions

What are your strengths and in what ways can you help support your peers throughout the program?

In what areas would you like to grow and in what way can your peer help you with these areas?

How would your coworkers describe you/in what ways can they depend on you?

What “stresses you out”?

Describe a time when you had multiple responsibilities/projects/assignments due and what steps you took to get them all completed on time and of high quality?

In the above example, what did you learn and what might you do differently?

Give an example of something big that you have overcome. How did you do it? What did you learn?

Three things that you are concerned about going forward and how you propose to overcome them:

1.

2.

3.

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Name

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Date



# Monroe Community College

STATE UNIVERSITY OF NEW YORK

Date

Name/Title of reference

Address

Name:

I am applying to the MCC LPN program this (Spring/Fall). I would be honored if you would provide MCC with a letter of recommendation for me to assist them with their selection process. This letter of recommendation must be on your company letterhead, be signed, and speak to how you know me. In addition, please indicate your knowledge of things such as my attendance and punctuality, work ethic, responsibility and reliability, and personality/character.

Thank you for your consideration and timely completion. These letters are due by (date). You can e-mail this letter to [Kelsey Klopfer \(kklopfer@monroecc.edu\)](mailto:kklopfer@monroecc.edu) or mail to:

Healthcare Programs: attn LPN  
EDIWS, 7<sup>th</sup> floor  
321 State Street  
Rochester, NY 14608

Sincerely,

## Essay Rubric

Criteria	3 pts	2 pts	1 pt
<b>Organization</b>	Clear introduction, body, conclusion. Responded to assignment with clear thesis followed by at least three ideas. Clear topic sentences, good use of transitions, connections between paragraphs.	Most, not all. Introduction there but not as clear, less than three ideas, some transitions, connections are okay.	Some of elements listed.  Not clear, minimal transitions and connections do not work.
<b>Development</b>	Uses specific, concrete examples. Explains connections and ideas are thoughtful and thorough. Explains relevance and significance.	Mostly uses specific examples, explains some connections. Not as thoughtful or thorough.	Lacks significant detail to support ideas, does not explain connection.
<b>Mechanics</b>	Demonstrates excellent use of language, free from spelling and grammatical errors. Proper sentence structure and paragraph format. Essay is typed.	Mostly free from error. Mostly formatted appropriately, sentence structure may be vague or imprecise, simple or a bit awkward, but mostly there.	Words misspelled and misused, choppy and frequent grammatical errors.  Essay is typed. No points awarded for untyped.



## Practical Nursing Program Health Release Form

Completion of this form is required to participate in the clinical portion of the Certified Nurse Assistant Training Program. Please complete all sections, front and back, and be sure you sign and date where it's requested. Your physician or health care provider needs to complete the Physician/Health Care Provider Section.

All entries made need to be in ink.

### Section 1: To Be Completed by Individual

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_

Cell Number: \_\_\_\_\_ Alt. Number: \_\_\_\_\_ Name: \_\_\_\_\_

### Section 2: To Be Completed by Physician or Health Care Provider or Provide Record

Immunizations required for all medical programs for clinical participation.

**2 Step PPD Skin Test or T-Spot** (Minimum 1 week apart)      **PPD#1:** Date Given: \_\_\_\_\_ (MM/DD/YY)      Date Read: \_\_\_\_\_ (MM/DD/YY)      Result: \_\_\_\_\_ POS\*/NEG

**PPD#2:** Date Given: \_\_\_\_\_ (MM/DD/YY)      Date Read: \_\_\_\_\_ (MM/DD/YY)      Result: \_\_\_\_\_ POS\*/NEG

\*Positive PPD, chest X-ray results: Date: \_\_\_\_\_ (MM/DD/YY)      Result:      Normal      Abnormal

Healthcare Provider Signature/Stamp if no copy attached (PPD)

Date Healthcare Provider Signed (PPD)

**MMR (Mumps, Measles, Rubella):**      MMR Vaccine #1 \_\_\_\_\_ (MM/DD/YY)      MMR Vaccine #2 \_\_\_\_\_ (MM/DD/YY)

Or Positive MMR Blood Titer:      Measles \_\_\_\_\_ (MM/DD/YY)      Mumps \_\_\_\_\_ (MM/DD/YY)      Rubella \_\_\_\_\_ (MM/DD/YY)

Healthcare Provider Signature/Stamp if no copy attached (MMR)

Date Healthcare Provider Signed (MMR)

Influenza Vaccine:      Attach copy

COVID-19 – provide card for proof:      Attach copy

### Section 3 Only: Physician or Health Care Provider

Carefully read the following statement, and check the appropriate box.

Based on my medical evaluation, to the best of my knowledge, this individual is free from physical or mental impairments which might interfere with his or her ability to participate in the Licensed Practical Nurse Program to include the following activities: bending, stretching, reaching, and lifting up to fifty pounds.

Yes

No

**If No is checked,** please identify those problems which might interfere with the performance of his/her duties or would pose a potential risk to patients or personnel. If applicable, please indicate **Pregnancy Restrictions.**

Physician's/Health Care Provider's (with Title) Signature

Print Physician's/Health Care Provider's Last Name/Stamp

Date Physician/Health Care Provider Signed

Signature here is for Section 3 only.



#### Section 4: Student & /or Provider Complete This Section

1. **Meningitis Vaccine:** [Note: ACIP recommends all first-year college students up to 21 years should have at least 1 dose of Meningococcal ACWY vaccine not more than 5 years before enrollment, preferably on or after their 16th birthday.]

- a. Meningitis Vaccine #1 \_\_\_\_\_ Meningitis Vaccine #2 \_\_\_\_\_  
OR
- b. I have reviewed the [information regarding meningococcal disease online \(https://www.health.ny.gov/publications/2168/\)](https://www.health.ny.gov/publications/2168/) and in print in the health office, or at [Health Services webpage \(https://www.monroecc.edu/depts/stuhealth/health-program-students/\)](https://www.monroecc.edu/depts/stuhealth/health-program-students/). I understand the risks of not receiving the vaccine. I have decided that I (my child) will not obtain immunization against meningococcal disease. I understand this does not prevent me (my child) from receiving the vaccine in the future, from my private health care provider, local health department or the Monroe County Health Department's Immunization Clinic at 111 Westfall Rd, Rochester, NY 14620. Phone 585-753-5150.

\_\_\_\_\_  
Student (or parent of a minor student) Signature (Meningitis)

\_\_\_\_\_  
Date Student Signed (Meningitis)

2. **Hepatitis B Information:**

I understand that due to my occupational exposures to blood I may be at risk of acquiring Hepatitis B virus Infection. I did receive the Hepatitis B immunizations. Please enter dates of each dose below. If you are in the middle of receiving the series please check the box to decline and sign and date where appropriate. Continue to send in the dates as they are received.

Hepatitis B Dose #1 \_\_\_\_\_

**OR** Decline the vaccine at this time; I understand that by declining I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood and wish to be vaccinated, I can receive the vaccines from my physician or the health care agency that employs me.

Hepatitis B Dose #2 \_\_\_\_\_

Hepatitis B Dose #3 \_\_\_\_\_

\_\_\_\_\_  
Student (or parent of a minor student) Signature (Hepatitis B)

\_\_\_\_\_  
Date Student Signed (Hepatitis B)

3. **Varicella Vaccine (Chicken Pox):** Varicella Vaccine #1: \_\_\_\_\_ Varicella Vaccine #2: \_\_\_\_\_  
(MM/DD/YY) (MM/DD/YY)

OR Positive Varicella Titer: Varicella \_\_\_\_\_  
(MM/DD/YY)

OR Date of Varicella Disease: Disease: \_\_\_\_\_  
(MM/DD/YY)

OR

I have reviewed the [information regarding varicella disease available online \(https://www.cdc.gov/chickenpox/vaccination.html\)](https://www.cdc.gov/chickenpox/vaccination.html). I understand the risks of not receiving the vaccine. I have decided that I will not obtain immunization against varicella disease. I understand this does not prevent me from receiving the vaccine in the future, from my private health care provider, local health department or the Monroe County Health Department's Immunization Clinic at 111 Westfall Rd, Rochester, NY 14620. Phone 585-753-5150.

\_\_\_\_\_  
Student (or parent of a minor student) Signature (Varicella)

\_\_\_\_\_  
Date Student Signed (Varicella)

4. **TD or TDAP:** TD/TDAP Vaccine #1 \_\_\_\_\_  
(MM/DD/YY, Administered within 10 years)

OR

I have reviewed the [information regarding varicella disease available online \(https://www.cdc.gov/vaccines/vpd/dtap-dtap-hcp/recommendations.html\)](https://www.cdc.gov/vaccines/vpd/dtap-dtap-hcp/recommendations.html). I understand the risks of not receiving the vaccine. I have decided that I will not obtain the TDAP immunization. I understand this does not prevent me from receiving the vaccine in the future, from my private health care provider, local health department or the Monroe County Health Department's Immunization Clinic at 111 Westfall Rd, Rochester, NY 14620. Phone 585-753-5150.

\_\_\_\_\_  
Student (or parent of a minor student) Signature (TD/TDAP)

\_\_\_\_\_  
Date Student Signed (TD/TDAP)

**Return To:** Monroe Community College, Workforce Development /Healthcare, Email: [Kelsey Klopfer \(kklopfer@monroecc.edu\)](mailto:Kelsey Klopfer (kklopfer@monroecc.edu))  
321 State Street., Rochester, NY 14623